MASS/DEPARTMENT OF PUBLIC HEALTH DPH-FL-C (monthly)
MONTHLY DISTRIBUTION SYSTEM SPLIT TESTING FLUORIDATION REPORT

Month of _____, 20__ __ Page __ of __

The data from this report will be used to evaluate the accuracy of the PWS fluoride testing equipment or laboratory.
Each month, at least one (1) distribution sample must be split and analyzed by the PWS and a Mass. laboratory certified for fluoride.[1]
Any questions, please call the Mass DPH Fluoridation Program at 617-624-6074.

Section I. PWS SAMPLING INSTRUCTIONS (PWS are required to take the following actions)

1. Collect a fluoride sample from the location checked on Form FL-B.
2. Divide the sample into two. The PWS must analyze one portion ("A") for fluoride using Std. Methods approved analytical method for fluoride analysis. e.g. specific ion or colorimetric method. The other portion of the sample ("B" or "split sample") must be sent for analysis within 96 hours of collection, to a laboratory that is certified by MassDEP for fluoride analysis. [1]
3. Record below, in Section II, all requested information for portion "A".

Section II. PWS INFORMATION: (To be completed and signed by PWS)

1. PWS Name: _____ 2. PWS ID#: _____ 3. City/Town or District: _____
4. List all contributing fluoridated source(s)/MassDEP Source Code/Location ID: _____
5. Name of PWS operator performing sample analysis: _____
6. Make and Model # of PWS fluoride analyzer: _____

Sample # or Location Name & Address from Form FL-B	**Bottle #**	**Results (PPM)** (To the nearest 0.1)	**Sample Collector's Name (Print)**	**Date Sample Collected by PWS**	**Date Sample Analyzed by PWS**

I certify under penalty of law that I am the person authorized to fill out this form and the information contained herein is true, accurate and complete to the best of my knowledge and belief.
Name of PWS operator or responsible party: _____ Signature: _____ Date: _____
Phone #: _____ Fax#: _____ Email address: _____

Section III. LABORATORY ANALYTICAL INFORMATION: (To be completed and signed by Lab)

Lab name: _____ MassDEP Lab Cert.#: _____ Lab phone: _____
Lab address: _____
Is this lab certified by MassDEP for fluoride analysis? Yes ☐ No ☐. If no, is a subcontracted lab used? Yes ☐ No ☐
Subcontracted lab name: _____ Sub lab MassDEP Cert #: _____
Is this subcontracted laboratory certified by MassDEP for fluoride analysis? Yes ☐, No ☐

Sample Location No.	**Sample Location Name & Address**	**Bottle #**	**Lab sample ID#**	**Results (PPM)** (To the nearest 0.1)	**Detection limit**	**Analytical Method**	**Date Analyzed**

My certified analytical results for the sample listed by the PWS as 01F is _____. _____ ___ PPM.
Check the correct answer: ☐ **My laboratory** result is **Within** +/- 0.1 of the result listed by the PWS for 01F.
☐ **My laboratory** result is **Not Within** +/- 0.1 of the result listed by the PWS for 01F.*****
***PWS must contact the Office of Oral Health at 617-624-6074 within 7 days of learning of this checked result.**
I certify under penalty of law that I am the person authorized to fill out this form and the information contained herein is true, accurate and complete to the best of my knowledge and belief.
Name of Laboratory Director: _____ Signature: _____ Date: _____

[1] If a PWS uses a Mass. certified lab for its daily samples it must use a different Mass. certified lab. for the required split sample.

Section IV. DPH USE ONLY

Date received _____ Approved: _____ Deficient/Comments: _____

Within 30 days of receipt of results and no later than 10-days after the end of the reporting period, PWSs approved by MassDEP for Fluoridation treatment must mail 1 copy of each page of this report form (A, B, & C) to: MA Dept. of Public Health, 250 Washington Street, 5th Floor, Boston, MA 02108-4619 Att: Office of Oral Health